WASATCH CITY-COUNTY HEALTH DEPARTMENT

805 WEST 100 SOUTH
HEBER CITY, UTAH 84032
PHONE (801) 654-2700

3-21-86

Dear Dr.

The health department has had some concern as to the lack of early detection of pregnancy and the resultant lapse of time that expectant mothers receive prenatal care.

The state health department has provided us with a number of pregnancy test kits at no charge which will enable us to do pregnancy testing for a minimal service fee. If pregnancy is confirmed we would immediately refer the woman to their physician which we hope would result in earlier prenatal care under their doctors direction.

We will use either the Sensi-Tex or Pregnosis tests which are latex agglutination inhibition tests.

The health board feels that this service would be a valuable asset to the community inasmuch as there may be some reluctance by certain individuals to go to a physician for early pregnancy testing. We know that the earlier expectant mothers begin prenatal care, the better the pregnancy outcome.

If you have any feelings either for or against the health department conducting this program would you please let us know. As always we invite your input into any of our public health programs.

Thank you for the excellent medical services that you provide in the community.

Thank you,

Phil D. Wright, M.S., R.S.
Health Officer

PDW/pt

Jim Maddox, Chidester Springs
(at junction of Highways 40 & 189 So Heber)

Store (215 No Main Heber)

" (750 So Main Heber)

1590 So. 215 Hiway 40 — Neal Cook)

Country Store # 217 (315 No Main Heber)

K Depot (95 So Main — Neal Cook)

~~(200 North Main~~ St Heber — Joe VanWagoner)

Yogurt (— So Main St — Neal Cook)

DR. R. R. GREEN
375 E. 2ND ST. No.
HEBER CITY, UTAH
84032

WASATCH CITY-COUNTY HEALTH DEPARTMENT

805 WEST 100 SOUTH
HEBER CITY, UTAH 84032
PHONE (801) 654-2700

March 24, 1986

R. Raymond Green
45 South Main
Heber City, Utah 84032

Dear Dr. Green,

The health department has had some concern as to the lack of early detection of pregnancy and the resultant lapse of time that expectant mothers receive prenatal care.

The state health department has provided us with a number of pregnancy test kits at no charge which will enable us to do pregnancy testing for a minimal service fee. If pregnancy is confirmed we would immediately refer the woman to their physician which we hope would result in earlier prenatal care under their doctors direction.

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Thank you,

Phil D. Wright

Phil D. Wright, M.S., R.S.
Health Officer

PDW/pt

GARBAGE CONTAINS ANY DIRT OR ROCK
GARBAGE CONTAINS ANY SCRAP IRON
GARBAGE CONTAINS TREE LIMBS OR LARGE WOOD
GARBAGE CONTAINS HOT CINDERS OR HOT ASHES

PLEASE TRY TO KEEP LIDS ON GARBAGE CANS
DURING STORMY WEATHER.

GARBAGE WILL BE PICKED UP THE WORK DAY
FOLLOWING ANY CITY OBSERVED HOLIDAY

HOLIDAY DATES TO REMEMBER:

JANUARY	1	1982
FEBRUARY	15	1982
APRIL	23	1982
MAY	31	1982
JULY	5	1982
JULY	23	1982
SEPTEMBER	6	1982
OCTOBER	11	1982
NOVEMBER	11	1982
NOVEMBER	25	1982
DECEMBER	24	1982

BUSINESS PLACES WITH CANNISTERS SHOULD
KEEP THE LIDS ON THE CANNISTERS CLOSED
DURING STORMY WEATHER.

BUSINESS PLACES WITH CANNISTERS SHOULD
KEEP THE SNOW AND ICE AWAY FROM THE
CANNISTERS TO ALLOW TRUCKS TO GET TO
THEM FOR PICKUP.

* *

DOG LICENSES ARE DUE JANUARY 1, 1982

DOG LICENSES BECOME DELINQUENT MARCH 1, 1982

* *

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

J. Brett Lazar, M.D., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 533-6191

MONTH April YEAR 1986

CONTENTS

ENCEPHALITIS SURVEILLANCE

Physicians are reminded that serum specimens should be collected from all patients suspected of being infected with an arthropod-borne viral encephalitis. Acute and convalescent serums (the convalescent should be collected 2-3 weeks after onset of illness) can be sent to the State Health Laboratory for complement fixation testing. Cerebrospinal fluid and tissues collected at autopsy can be examined if frozen immediately and kept frozen in dry ice until delivery to the laboratory.

Surveillance in Utah is directed toward early identification of viral transmission by the Culex tarsalis mosquito. Of major concern are the viruses which cause western equine encephalitis and St. Louis encephalitis. Sentinel chicken flocks have been distributed throughout Utah to detect sero-conversions. Veterinarians are also collecting specimens from horses suspected of being infected. C. tarsalis larvae have already been reported this year from several areas of the State. Mosquito abatement personnel also report that vegetation has now grown to match high water levels and can be expected to provide increased breeding grounds for mosquitoes.

The Bureau of Epidemiology would appreciate receiving telephone reports when arthropod-borne encephalitis is suspected (538-6191).

RECOMMENDED INFECTION CONTROL PRACTICES FOR DENTISTRY[1]

The Centers for Disease Control has issued a set of infection control strategies designed to prevent the transmission of hepatitis B, acquired immunodeficiency syndrome (AIDS) and other infectious diseases caused by bloodborne viruses.

The use of protective attire and barrier techniques are stressed. Especially important are recommendations that gloves be worn when touching blood, saliva, or mucuous membranes. Gloves must also be worn when handling blood-soiled items, body fluids, or secretions, as well as surfaces contaminated with these items. Surgical masks and protective eyewear or chin-length plastic face shields are advised when splashing or splattering of blood or other blody fluids is likely.

Single complimentary copies of the complete guidelines are available from the Bureau of Epidemiology.

Reference: [1] Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 35/No. 15, April 18, 1986.

RHEUMATIC FEVER -- INCREASED INCIDENCE

Cardiologists at Primary Children's Medical Center have reported a dramatic increase in cases of rheumatic fever over the last 18 months. The Utah Department of Health is establishing a comprehensive case registry to aid in the investigation of reported cases.

Although rheumatic fever is a reportable disease, most physicians have not been reporting cases. Due to the increased incidence, the Utah Department of Health is requesting that all physicians fill out a Confidential Morbidity Report Card for each case. The report card should be mailed to the local health department in the prepaid postage envelope. Report cards and envelopes may be obtained from the local health departments. Each reported case will be verified according to the Jones Criteria (Revised) for Guidance in the Diagnosis of Rheumatic Fever.

The Jones Criteria was intially proposed in 1944 and revised in 1965 by the American Heart Association. While there is no single laboratory test, sign or symptom pathognomonic of acute rheumatic fever, several combinations of symptoms are diagnostic. The criteria were developed to establish the diagnosis during the acute stage of rheumatic fever and are not constructed to predict the course or severity of the disease.

The criteria are not substitutes for clinical judgement, but are designed to guide physicians in the diagnosis of rheumatic fever. Such standardized criteria facilitate the collection of accurate incidence data and evaluation of the effectiveness of prevention programs.

The clinical and laboratory criteria are divided into major and minor categories, based upon the diagnostic importance of a particular finding. The presence of TWO MAJOR CRITERIA or of ONE MAJOR AND TWO MINOR CRITERIA, indicates a high probability of the presence of acute rheumatic fever, if supported by evidence of a preceding Group A streptococcal infection.

The criteria are:

MAJOR CRITERIA	MINOR CRITERIA
Carditis (murmurs, cardiomegaly, pericarditis, congestive heart failure)	Clinical (previous history of rheumatic fever, arthralgia or fever)
Polyarthritis	Electrocardiographic changes
Chorea	Elevated anti-streptolysin O titer
Erythema marginatum	Elevated erythrocyte sedimentation rate
Subcutaneous nodules	Positive throat culture for Group A streptococcus

The Utah Department of Health is most anxious to collect data on all cases of acute rheumatic fever treated in Utah, and urges all practitioners to obtain the confidential report cards and report any cases they treat.

For a copy of the Jones Criteria (Revised), or more information on reporting rheumatic fever cases, please contact Joan Ware, Bureau of Chronic Disease, P.O. Box 16700, Salt Lake City, Utah 84116-0700 or telephone (801) 538-6141.

Safety of Therapeutic Immune Globulin Preparations with Respect to Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection

Immune globulins produced by plasma fractionation methods approved for use in the United States have not been implicated in the transmission of infectious agents. Nevertheless, because immune globulins manufactured before 1985 were derived from plasma of human donors who were not screened for antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), CDC and the U.S. Food and Drug Administration (FDA) have received inquiries concerning the safety of immune globulin (IG), hepatitis B immune globulin (HBIG), and intravenous immune globulin (IVIG). Current epidemiologic and laboratory evidence shows that these preparations carry no discernable risk of transmitting HTLV-III/LAV infection and that current indications for their clinical use should not be changed based on such concerns.

BACKGROUND

The IG, HBIG, IVIG, and other special immune globulins used in the United States are produced by several manufacturers using the Cohn-Oncley fractionation process (*1,2*). This process involves a series of precipitation steps performed in the cold with addition of varying concentrations of ethanol. Production lots of IG and IVIG are made from plasma pools from at least 1,000 donors; HBIG and other specific immune globulins (e.g., varicella-zoster IG) may be prepared from plasma pools from fewer donors.

Before 1985, donors were screened only for hepatitis B surface antigen but not by other tests for specific diagnosis of viral infections. Since April 1985, all donor units also have been screened for antibodies to HTLV-III/LAV, and all repeatedly reactive units have been discarded. Tests conducted at FDA and CDC have shown that as many as two-thirds of HBIG lots, as well as some lots of IG and IVIG, produced between 1982 and 1985 may have been positive for HTLV-III/LAV antibody. The question of safety arises out of concern that some immune globulins currently available were prepared from plasma pools that included units from donors who may have had HTLV-III/LAV viremia.

EPIDEMIOLOGIC STUDIES

Several studies have shown that recipients of HBIG and IG, including recipients of lots known to be positive for antibody to HTLV-III/LAV, did not seroconvert to antibody to HTLV-III/LAV-positivity and have not developed signs and symptoms of acquired immunodeficiency syndrome (AIDS) or other illnesses suggesting HTLV-III/LAV infection.

Since August 1983, CDC has enrolled 938 individuals who have had parenteral or mucous-membrane exposures to blood or body fluids of AIDS patients in a prospective surveillance study. To date, 451 entrants have been followed and tested for HTLV-III/LAV antibody. Of these, 183 persons received IG and/or HBIG as prophylaxis against hepatitis B infection; 100 (55%) received only IG; 65 (36%) received only HBIG; and 18 (10%) received both. One of the 183 HBIG recipients is now positive for HTLV-III/LAV antibody, but no preexposure serum was available for this individual, and seropositivity may have predated the needlestick exposure and IG prophylaxis. Further, heterosexual transmission of HTLV-III/LAV infection in this individual cannot be ruled out. No documented seroconversions have occurred in any of the 183 health-care workers who received IG or HBIG.

Studies have been reported of 16 subjects who received HBIG that was strongly positive for HTLV-III/LAV antibody (*3*). Each patient had been given one to five ampules. A total of 31 doses were administered to 16 individuals. Low levels of passively acquired HTLV-III/LAV antibody were detected shortly after injection, but reactivity did not persist. Six months after the last HBIG injection, none of the 16 individuals had antibody to HTLV-III/LAV.

In a study of prophylaxis against cytomegalovirus (CMV) infections among kidney-transplant patients, 16 patients received CMV-specific IVIG preparations subsequently found to contain HTLV-III/LAV antibody. After 10 months or longer of follow-up, none of the 16 recipients developed antibody or other evidence of HTLV-III/LAV infection.

In studies of a group of IVIG recipients, most of whom had idiopathic thrombocytopenia, none of 134 patients developed antibodies or other evidence of HTLV-III/LAV infection.

Information regarding past therapy with immune globulins is available from 10,227 of 17,115 AIDS patients reported to CDC. Three hundred fifty-eight (4%) reported receipt of an IG preparation. All but seven of these patients also were members of groups known to be at high risk for developing AIDS. The percentage of patients with no recognized risk factors for AIDS was not significantly different among those who received immune globulins (7/358 [2%]) than among those who did not (358/9,869 [4%]).

LABORATORY STUDIES

Scientists at FDA recently evaluated the basic fractionation processes (*1,2*) used for production of immune globulins to determine effectiveness of those procedures in eliminating HTLV-III/LAV infectivity (*4*). Six sequential steps in a typical process were evaluated. The study was designed so that efficiency of eliminating HTLV-III/LAV at each step was measured. The degree to which HTLV-III/LAV was reduced by partitioning or inactivation at individual steps ranged from 10^{-1} to more than 10^{-4} of in vitro infectious units (IVIU)/ml. The effectiveness of virus removal in the entire process by partitioning and inactivation was calculated to be greater than 1×10^{15} IVIU/ml.

Concentrations of infectious HTLV-III/LAV in plasma of infected persons have been estimated to be less than 100 IVIU/ml. Further, FDA scientists have shown that the geometric mean infectivity titer of plasma from 43 HTLV-III/LAV infected persons was 0.02 IVIU/ml (*4*). Thus, the margin of safety based on the removal of infectivity by the fractionation process is extremely high.

Scientists at CDC and FDA also cultured 38 lots of HBIG, IVIG, and IG, most of which contained HTLV-III/LAV antibody. HTLV-III/LAV was not recovered from any lot tested.

Reported by J Bossell, MD, Cornell University, New York City; Central Laboratories Swiss Red Cross Blood Transfusion Svc, Berne, Switzerland; Immuno A.G., Vienna, Austria; KabiVitrum AB, Stockholm, Sweden; Massachusetts Public Health Biologics Laboratories, Boston, Massachusetts; Miles Laboratories, Inc., Berkeley; Travenol Laboratories, Inc., Glendale, California; Center for Drugs and Biologics, U S Food and Drug Administration; Center for Infectious Diseases, CDC.

Editorial Note: The laboratory and epidemiologic studies referred to have shown that concern about HTLV-III/LAV infection associated with the use of immune globulins available in the United States is not warranted. Strategies for using immune globulins recommended by the Immunization Practices Advisory Committee should be followed (*5*).

Recently, concern has been expressed that patients who received IG prepared from plasma of donors not screened for HTLV-III/LAV antibody may have a passively acquired false-positive reaction for antibody (*6*). Passively acquired HTLV-III/LAV antibody from HBIG known to contain high levels of antibody has been reported (*3*). Based on the estimated half-life of globulins in plasma, it can be calculated that passively acquired antibodies might be detected in sera of recipients for as long as 6 months after administration of immune globulins. It is important to recognize this possibility when attempting to determine the significance of HTLV-III/LAV antibody in a person who has recently received immune globulins, especially HBIG. (References available upon request.)

Reference: Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol.35/No.14, 4/11/86.

Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus during Invasive Procedures

BACKGROUND

On November 15, 1985, "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace," was published (*1*). That document gave particular emphasis to health-care settings and indicated that formulation of further specific recommendations for preventing human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) transmission applicable to health-care workers (HCWs) who perform invasive procedures was in progress.

Toward that end, a 2-day meeting was held at CDC to discuss draft recommendations applicable to individuals who perform or assist in invasive procedures.* Following the meeting, revised draft recommendations for HCWs who have contact with tissues or mucous membranes while performing or assisting in operative, obstetric, or dental invasive procedures were sent to participants for comment. In addition, 10 physicians with expertise in infectious diseases and the epidemiology of HTLV-III/LAV infection were consulted to determine whether they felt additional measures or precautions beyond those recommended below were indicated. These 10 experts did not feel that additional recommendations or precautions were indicated.

DEFINITIONS

In this document, an operative procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices. An obstetric procedure is defined as a vaginal or cesarean delivery or other invasive obstetric procedure where bleeding may occur. A dental procedure is defined as the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, where bleeding occurs or the potential for bleeding exists.

RECOMMENDATIONS

There have been no reports of HTLV-III/LAV transmission from an HCW to a patient or from a patient to an HCW during operative, obstetric, or dental invasive procedures. Nevertheless, special emphasis should be placed on the following precautions to prevent transmission of bloodborne agents between all patients and all HCWs who perform or assist in invasive procedures.

1. All HCWs who perform or assist in operative, obstetric, or dental invasive procedures must be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection and the need for routine use of appropriate barrier precautions during procedures and when handling instruments contaminated with blood after procedures.
2. All HCWs who perform or assist in invasive procedures must wear gloves when touching mucous membranes or nonintact skin of all patients and use other appropriate barrier precautions when indicated (e.g., masks, eye coverings, and gowns, if aerosolization or splashes are likely to occur). In the dental setting, as in the operative and obstetric setting, gloves must be worn for touching all mucous membranes and changed between all patient contacts. If a glove is torn or a needlestick or other injury occurs, the glove must be changed as promptly as safety permits and the needle or instrument removed from the sterile field.
3. All HCWs who perform or assist in vaginal or cesarean deliveries must use appropriate barrier precautions (e.g., gloves and gowns) when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin. Recommendations for assisting in the prevention of perinatal transmission of HTLV-III/LAV have been published (*2*).
4. All HCWs who perform or assist in invasive procedures must use extraordinary care to prevent injuries to hands caused by needles, scalpels, and other sharp instruments or devices during procedures, when cleaning used instruments, during disposal of used needles, and when handling sharp instruments following procedures. After use, disposable syringes and needles, scalpel blades, and other sharp items must be placed in puncture-resistant containers for disposal. To prevent needlestick injuries, needles should not be recapped, purposefully bent or broken, removed from disposable syringes, or otherwise manipulated by hand. No data are currently available from controlled studies examining the effect, if any, of the use of needle-cutting devices on the incidence of needlestick injuries.
5. If an incident occurs during an invasive procedure that results in exposure of a patient to the blood of an HCW, the patient should be informed of the incident, and previous recommendations for management of such exposures (*1*) should be followed.
6. No HCW who has exudative lesions or weeping dermatitis should perform or assist in invasive procedures or other direct patient-care activities or handle equipment used for patient care.
7. All HCWs with evidence of any illness that may compromise their ability to adequately and safely perform invasive procedures should be evaluated medically to determine whether they are physically and mentally competent to perform invasive procedures.
8. Routine serologic testing for evidence of HTLV-III/LAV infection is not necessary for HCWs who perform or assist in invasive procedures or for patients undergoing invasive procedures, since the risk of transmission in this setting is so low. Results of such routine testing would not practically supplement the precautions recommended above in further reducing the negligible risk of transmission during operative, obstetric, or dental invasive procedures.

Previous recommendations (*1,3,4*) should be consulted for: (1) preventing transmission of HTLV-III/LAV infection from HCWs to patients and patients to HCWs in health-care settings other than those described in this document; (2) preventing transmission from patient to patient; (3) sterilizing, disinfecting, housekeeping, and disposing of waste; and (4) managing parenteral and mucous-membrane exposures of HCWs and patients. Previously recommended precautions (*1*) are also applicable to HCWs performing or assisting in invasive procedures.

References

1. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III lymphadenopathy-associated virus in the workplace. MMWR 1985;34:682-6, 691-5.
2. CDC. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III lymphadenopathy-associated virus and acquired immunodeficiency syndrome. MMWR 1985;34:721-6, 731-2.
3. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
4. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.

Reference:

Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 35/No. 14, April 11, 1986.

WASATCH CITY-COUNTY HEALTH DEPARTMENT

805 WEST 100 SOUTH
HEBER CITY, UTAH 84032
PHONE (801) 654-2700

April 8, 1986

Dear Board Member or Spouse,

The health department would like to run a series of articles in the Wave concerning board of health members so the public can become better aware of the health board. In order to make the article informative we would like the following information:

1. Activities past and present in the community. (Anything of interest).
2. Present occupation and past experience in areas that would give you expertise.
3. Major concerns or focus of interest as a board member.
4. Personal interests.
5. Feelings as a member of the board.
6. Any other information you would like in the article.

We would also like a photo of you that would accompany the article. Please have this information back to us by the board meeting in May or we'll make something up and you'll live to regret it.

Thanks,

Phil

Byu Book

Copy of 1860 Census Weber Co Utah

Census complete

Heads of Families

Unit — 4

see Census Records in General Library

Census

Provo River Valley

Utah Co

AGENDA

BOARD OF HEALTH

APRIL 21, 1986

12:00 P.M.

WASATCH COUNTY SERVICES COMPLEX

1) School Board Appointment -(Jeff Bradshaw)

2) Mental Health Report - Larry Carcelli

3) Alcohol & Drug Report - Rob Blanthorn

4) WIC 317

5) Well Child 19

6) Hypertension 20

7) Pregnancy Testing Hold off.

8) Immunization
   Kindergarten Registration
   Hib Vaccine – Purchace thru Feds 12 Drs 15.00 cost 3.00

9) Scoliosis middle school done

10) Contract Submission ← maternal / weld child / Early Preg
    Floride URI or Ear
    glasses
    Prenatal Care

11) EMS Council Phil is Chief.

12) ~~Heavy~~ Hearing wood burning stoves 24 Apr.

13) Asbestos Survey – 23 bldgs.

14) Food Service

15) Other Business

MINUTES OF THE WASATCH CITY-COUNTY BOARD OF HEALTH

April 21, 1986 12:10 P.M. County Services Complex

Present were:		
	Calvin Giles	Chairman
	Connie Tatton	Vice-chairman
	Elizabeth Murdock	Member
	R. Raymond Green, M.D.	Medical Officer
	R. C. Tadd	Commissioner
	Phil Wright	Health Officer
	Maxine Oakeson	Nurse Supervisor
	Robert Blanthorn	Alcohol/Drug Director
	Nelda Duke	Secretary

Welcome: Mr. Giles welcomed those present and called the meeting to order.

Invocation: Mrs. Oakeson gave the opening prayer.

Minutes: Minutes of the meeting held March 17, 1986 were read by Mrs. Duke. Mrs. Tatton made a motion minutes be approved as read. Commissioner Tadd seconded motion. Motion carried.

School Board Member: Mr. Giles stated that Jeff Bradshaw had been appointed by the school board to be their ex-officio representative to our board. A schedule of our meetings will be sent to him along with our minutes.

Smile Factory: Mrs. Tatton mentioned her children had been seen by a dentist in school. She asked if this was part of the "Smile Factory" dental program. Mrs. Oakeson said this was not part of our program but some dentists at the "Smile Factory" thought it would be good to check all school children. This is probably a result of the "Smile Factory" dental program.

Alcohol/Drug Report: Mr. Blanthorn reported he now has 21 clients which includes approximately 35 people being seen in the program. His budget was cut 4.3% until July and the Title XX budget is cut 25%. This will probably cause him to release his counselor in July. He may have to contract with a counselor on an hourly basis to take up the slack.
Mr. Blanthorn also stated the state wants him to purchase a computer. He is looking into possibilities.
Mr. Blanthorn stated plans for the Health Fair are well underway and they expect it to be a success this coming saturday.

Mountainlands Contract:	Commissioner Tadd said our contract through Mountainlands may not be available next year.
Pregnancy Testing:	Mr. Wright said he had sent a letter to all the county physicians asking how they felt about our department doing pregnancy testing. Mr. Wright has talked with a few of the doctors and they have voiced some concerns. After some discussion Dr. Green made a motion Mrs. Oakeson check into how other health nurses are handling this testing and Mr. Wright check with health officers and see how they are conducting this program and also check with the county attorney for liability concerns before doing further testing. Motion seconded by Mrs. Tatton. Motion carried.
Hib Vaccine:	Mr. Wright stated we have sent a request to purchase Hib vaccine. When we hear back from them we will buy the vaccine and it will be available to children of the county.
Kindergarten Registration:	Mrs. Oakeson stated the last week of this month will be kindergarten registration. We have set up three immunization clinics to accommodate these children.
Scoliosis:	Mrs. Oakeson stated Mrs. Durtschi has been doing some scoliosis screening in the schools. She has been showing a video on scoliosis to the students before doing the screening. This video is available at the health department and has been offered to the public.
Contracts:	Mrs. Oakeson reviewed the Child Health and Maternal Health contracts for FY86-87. (See copies #1 & 2).
Emergency Medical Services:	Mr. Wright stated the Emergency Medical Services council had prioritized their request for emergency equipment for the county. The #1 priority was extracation equipment, #2 training, #3 hand held radios, #4 air bag equipment and #5 EMT training. He said he felt we had a good chance of getting most of the high priority items.
Wood Burning Stoves- Hearing:	Mr. Wright said the hearing on wood burning stoves will be held Thursday, April 24th at 7:00 P.M. He discussed some of the regulations that will be enforced if the ordinance is adopted.
Asbestos Survey:	Mr. Wright reported he had completed the asbestos survey. He checked 23 buildings and submitted 12 samples - 9 were asbestos. It will be interesting to get the report back from the state.

Food Service:	Mr. Wright read a letter from the managers of the Blazing Saddles Cafe thanking us for insisting they bring their establishment up to health code. They are doing extensive remodeling and will ask for an inspection as soon as it is completed. Mr. Wright said the state will be awarding us a Food Service plaque at the next commission meeting. He commended the board for their support in this area.
Board Manual:	It was mentioned we need to update our board of health manuals.
Water Systems:	Mr. Wright stated since interest rates have lowered he has had several requests from people who want to refinance their homes. They are asking for approval for waste water disposal and water supply. Loan institutions will not loan on an unapproved system. As some water systems are unapproved in the county he is getting some flack. There was some discussion as to how we can encourage water systems to get their systems upgraded and approved.
Mayflower Tailings:	It was mentioned that there is a meeting on May 1, 1986 at 10:00 AM regarding the Mayflower Mine Tailings. Mr. Wright will attend this meeting.
Next Meeting:	The next meeting was scheduled for Monday, May 19, 1986 12:00 P.M. in the county services complex. Meeting adjourned at 1:50 P.M.

_____

Chairman

Public Hearings on Wood Burning Stoves Set

24 Apr 1986 Wave

The Utah Air Conservation Committee, Utah Department of Health has set a series of public hearings to receive comments on proposals to control the emissions from wood and coal burning stoves. The hearings will focus on three primary areas: 1) visibility standards for smoke from stoves, 2) performance standards for wood stoves and fireplace inserts, and 3) sulfur and ash limits on coal and coal containing products sold for residential burning.

The visibility standards considered by the committee would be a 40 percent visual opacity standard for wood and coal burning stoves, fireplaces and fireplace inserts. Forty percent would allow a visible plume of smoke from the chimney but not a plume of dark smoke. This proposal would include exceptions for a 15 minute start up period and a 7 minute refueling period each hour.

April 24, 7:00 p.m., Wasatch County Courthouse, County Courthroom 25 North Main, Heber City (Use Rear entrance to the courthouse.)

A NEW VACCINE TO MAKE THE WORLD A SAFER PLACE FOR YOUR CHILD

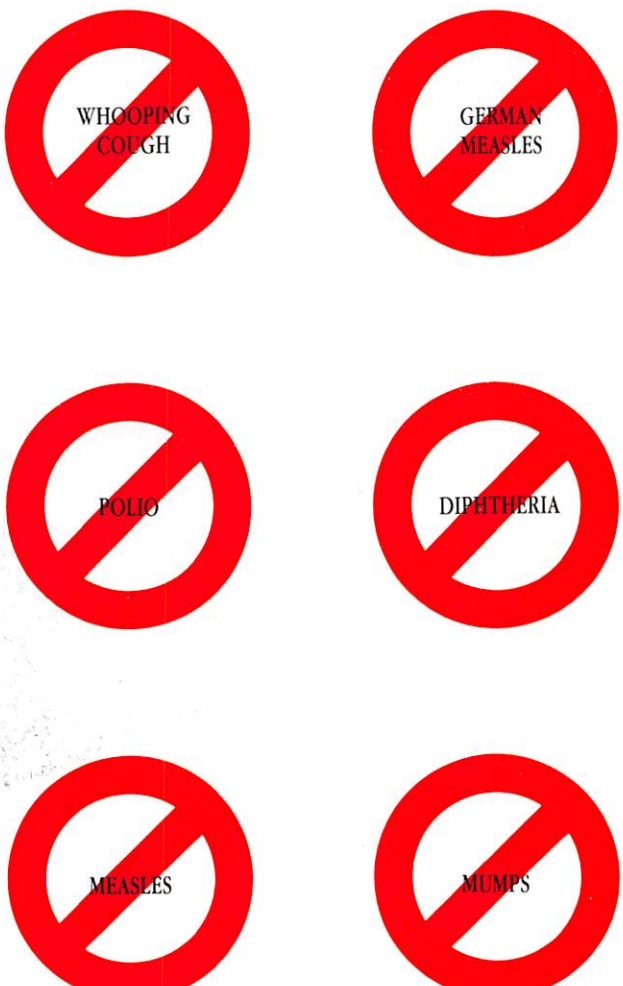
Provided by Mead Johnson NUTRITIONAL DIVISION
distributor of *b*-CAPSA™ I VACCINE
(Haemophilus b Polysaccharide Vaccine)

b-CAPSA™ I VACCINE is manufactured by
Praxis Biologics, Inc., Rochester, N.Y.

L B-0802-06-85

Why do we need a new vaccine?

For years, vaccines have helped prevent disease, especially in children. Polio, mumps, measles, German measles, whooping cough, and diphtheria used to cause a lot of sickness, permanent disability, and even death. We hardly hear of them anymore.



What should I do next?

Talk with your child's doctor. Your doctor can answer your questions about this new vaccine.

they are at particularly high risk of developing serious disease from Hib. Therefore, your physician may want to consider vaccination of children 2 to 6 years of age, and those 18 to 23 months, although the vaccine is less likely to be as effective in this latter age group.

Is there anything else I should know?

The less Hib disease, the safer your child will be. Parents, schools, and day-care centers can all help. You might want to learn if your child's playmates are vaccinated against Hib.

Now we can prevent another serious type of childhood illness. A bacterium ("germ") called *Haemophilus influenzae* type b is responsible for many infections in children. We'll call it by the initials Hib. Hib attacks one of every 200 children in the U.S. before age 5. It is responsible for:

- Over half of all cases of meningitis in children—a leading cause of acquired mental retardation. Between 5% and 10% of all children who develop Hib meningitis will die. And of those who survive, many have lasting damage to the nervous system.
- More than 90% of all cases of epiglottitis in children—a medical emergency that can cause a child to choke to death if it is not treated immediately.
- A major portion of all joint infections in children—a devastating and potentially crippling form of arthritis.

Serious Hib disease is contagious, so one sick child can make others sick. What's more, it is getting harder to treat Hib disease, because the bacterium is often resistant to antibiotics.

So our best hope is to *prevent* disease from Hib.

How does the new vaccine work?

Vaccines teach the body how to manufacture protective substances called antibodies. Antibodies are substances in the blood that kill harmful bacteria and viruses. Babies are born with antibodies obtained from their mothers. These antibodies protect the baby during the first few months of life. After that, the child's body must start making its own antibodies.

However, young children have immature antibody-producing systems and may not begin producing enough antibodies to defend against Hib until age 2, 3, or sometimes even older.

After an illness caused by a bacterium or virus, people develop antibodies to that germ. Vaccines do the same thing—teach the body how to make specific antibodies—but without causing sickness. The new vaccine teaches the child's body to manufacture antibodies to fight Hib.

But does it work?

Yes. More than 60,000 children around the world received earlier versions of the vaccine during their testing period. It has been estimated that routine vaccination could prevent thousands of cases of serious Hib disease in children up to age 5 each year in this country.

The vaccine is a highly purified product that has a very low rate of side effects, and most of those are minor; a short period of low-grade fever or a local reaction (usually swelling) at the injection site may occur in a few children.

After studying its record of safety and effectiveness, the Immunization Practices Committee of the U.S. Public Health Service and the American Academy of Pediatrics have recommended its use.

Who should be vaccinated?

The Immunization Practices Committee of the U.S. Public Health Service and the American Academy of Pediatrics recommend that all children receive the Hib vaccine at 24 months of age.

Because children in nursery school, day-care centers, and kindergarten come into close contact with so many other children,

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

J. Brett Lazar, M.D., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 538-6191

MONTH May YEAR 1986

CONTENTS

PUBLIC HTLV-III/LAV TESTING SITES

In the first 12 months of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) screening by local health departments, 525 specimens have been tested. Of these, 471 (90%) have been screened at either the Salt Lake City-County or the Weber-Morgan Health Department. An additional 7% have been seen at either the Bear River, Davis County, or Utah City-County Health Departments.

Currently there are five public HTLV-III/LAV testing sites in Utah. They are the five local health departments noted below:

Bear River District Health Department (Logan, 752-3730)
Davis County Health Department (Farmington, 451-3340)
Salt Lake City-County Health Department (Salt Lake, 530-7666)
City-County Health Department of Utah County (Provo, 375-7837)
Weber-Morgan District Health Department (Ogden, 399-8433)

During that same time period (April 1, 1985 - March 31, 1986), the Utah State Health Laboratory received 1,059 specimens for HTLV-III/LAV antibody screening. Of those, 508 (48%) were positive upon initial screening using the enzyme-linked immunosorbent assay (ELISA). Serum from 343 of the 508 (68%) were positive when the ELISA was repeated.

Western blot immunoelectrophoresis assays were conducted on 604 serum samples that were positive for antibodies to HTLV-III by ELISA at either the State Health Laboratory or other testing facilities in Utah. Two hundred ninety-four (49%) were positive by Western blot methodology.

In addition to HTLV-III/LAV screening and counseling, the five public HTLV-III/LAV testing sites will conduct selected sex partner follow-up. Staff will strongly encourage self-referral, that is, a seropositive patient will be asked to arrange for his/her sex partners to receive serologic testing and appropriate counseling. The Bureau of Epidemiology recommends that high priority contacts (i.e. needle-sharing partners, female contacts, prostitutes, and sexual contacts of confirmed AIDS patients) be epidemiologically traced and referred for screening and counseling. These recommendations are based upon the limited resources currently available and could be expanded in the future.

Recent medical studies have indicated that persons infected with Mycobacterium tuberculosis and HTLV-III/LAV are at increased risk of developing clinically active tuberculosis due to HTLV-III/LAV impairment of the immune system. It is therefore recommended that HTLV-III/LAV seropositive, as well as selected seronegative patients receive a Mantoux tuberculin skin test to determine their tuberculosis status.

Additionally, for similar immunologic reasons, HTLV-III/LAV seropositive patients should receive pneumoccocal (23-valent) and influenza vaccines to reduce the risk of developing pneumonia due to Streptococcus pneumoniae and influenza viruses. Standard medical practice, including consideration of contraindications, should still apply.

RUBELLA OUTBREAK IN A LONG-TERM CARE FACILITY: WEBER COUNTY

Almost two years have elapsed since Utah's last reported case of rubella. During May, 1986, however, four cases of rubella were serologically confirmed in a center for mentally retarded patients in Weber County. The cases range in age from 25 to 37 years. The onset date of the index case was April 27, 1986. A history of rubella immunity could not be documented for any of the cases. Another clinically compatible and epidemiologically linked case, still pending serologic confirmation, was an 18 year old former employee of the facility. The female was 8 1/2 weeks pregnant at the time of rash onset. At the present time, the outbreak appears to be confined to the facility, but physicians in the community should have a high index of suspicion for rubella when seeing patients with rashes.

Significant rubella susceptibility (approximately 20% in Utah) exists among young adults. Hospitals, long-term care facilities, and outpatient clinics present opportunities for young adult patients and staff to congregate and facilitate rubella transmission. Outbreaks in these settings can result in the infection of pregnant women, often with devastating consequences for the fetus. Managing such outbreaks is usually very time-consuming and costly.

In May, 1986, the Immunization Program mailed a Rubella Screening Survey questionnaire to all Utah hospitals; 97% responded. Among respondents, greater than 60% of acute care hospitals had a policy of screening hospital employees for their rubella immunity, but only 26% of those hospitals require immunizations for the employees identified as susceptible.

It is strongly recommended that each hospital, long-term care facility, outpatient clinic, and local health department/clinic require that all its employees who may have contact with female patients of childbearing age be immune to rubella. Persons should be considered immune only if they have documentation of:

1. Laboratory evidence of rubella immunity, or

2. Adequate immunization with rubella vaccine on or after the first birthday.

"THE FACTS OF LICE" VIDEOTAPE AVAILABLE

The educational video tape, "The Facts of Lice" is available for a one-week loan from the Bureau of Epidemiology. This one-half inch (VHS) training aid was developed at California State University and provides information on identification, treatment and prevention of head lice infestations. Please contact the Bureau (538-6191) to reserve this tape.

JAPANESE ENCEPHALITIS[1]

"Japanese encephalitis is a mosquito-borne viral encephalitis which occurs in epidemics during the summer months in India, Bangladesh, the eastern part of the Union of Soviet Socialist Republics, China, Korea, Nepal, Burma, Viet Nam, and northern Thailand. In other more tropical areas of southeast Asia, such as south India, south Thailand, and Sri Lanka, the disease is endemic, causing sporadic cases in local populations, and is transmitted at higher rates, occasionally of epidemic proportions, during the rainy season. The mosquitoes which transmit the virus are most active at dawn, dusk and on overcast days, but feed predominantly around sunset; they occur in greatest concentration in rural areas.

"No vaccine for Japanese encephalitis is currently licensed for use in the United States. The Division of Vector-Borne Viral Diseases, Center for Infectious Diseases, Centers for Disease Control holds an Investigational New Drug (IND) clearance from the Food and Drug Administration to make available on a limited basis a vaccine which is produced in Japan. This inactivated vaccine is given in 3 doses at 7-day intervals. Travelers who wish to inquire about administration of the vaccine should contact the Division of Vector-Borne Viral Disease in Fort Collins, Colorado at (303) 221-6429. Travelers may also inquire about the availability of the vaccine at American Embassies in destination countries where Japanese encephalitis is endemic.

"The risk to travelers who confine their travel to urban centers is low. The risk to short-term travelers (visits of several weeks or less) to non-urban areas is also relatively low, but varies with the season of the year. Travelers at increased risk are primarily those who will be in rural endemic or epidemic areas for extended periods, especially during the time of year when cases are likely to occur (June to October in temperate climates) and those who will be engaged in activities likely to expose them to the mosquito vectors, such as travel in rural areas.

"Precautions should be taken to guard against mosquito bites. These include sleeping in screened quarters or under mosquito netting, wearing clothing which leaves a minimum of bare skin, using insect repellents on exposed skin surfaces. Preferable repellents are those containing over 30 percent active ingredient (N,N-diethyl-meta-toluamide ["deet"])."

Reference: [1]Adapted from Centers for Disease Control, U.S. Public Health Service, Advisory Memorandum No. 86, March 21, 1986.

MALARIA PREVENTION RECOMMENDATIONS[1]

The Center for Prevention Services, Centers for Disease Control has updated information regarding prevention of malaria found in the 1985 booklet "Health Information for International Travel". While most of the recommendations are identical to those previously given, the following important information regarding chemoprophylaxis has been updated.

Chemoprophylactic Regimens

"Regimen A: For travel of ANY DURATION to areas of risk where chloroquine-resistant P. falciparum has NOT been reported or where only low level or focal chloroquine resistance has been reported, once weekly use of chloroquine alone is recommended. Chloroquine is usually well tolerated. The few people who experience uncomfortable side-effects may tolerate the drug better by taking it with meals, or in divided, twice-weekly doses. As an alternative, the related compound hydroxychloroquine may be better tolerated.

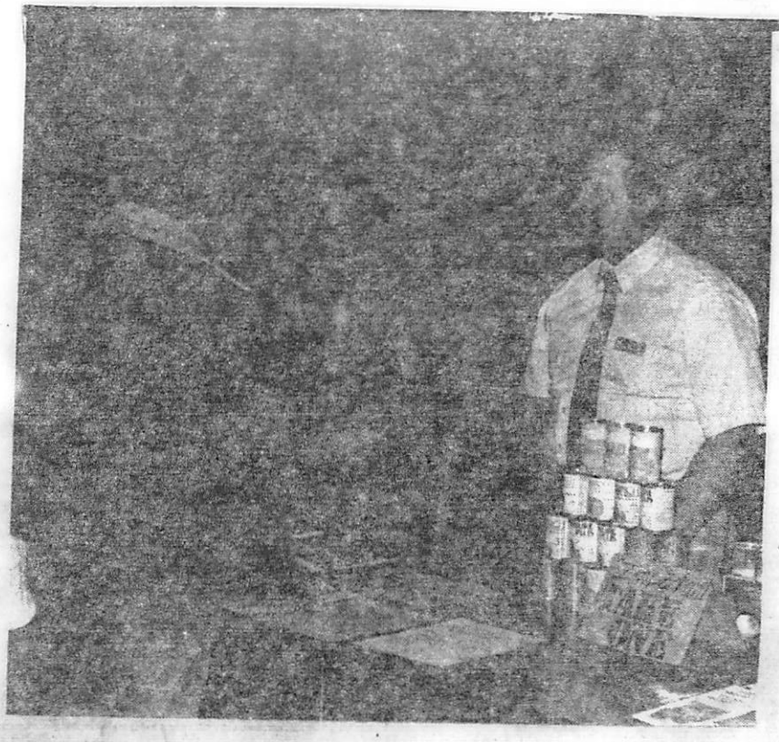
"Regimen B: For SHORT-TERM travel (3 weeks or less) to areas of risk where chloroquine-resistant P. falciparum IS endemic, once-weekly use of chloroquine alone is recommended. In addition, travelers to these areas (except those with histories of sulfonamide intolerance) should carry a treatment dose of Fansidar^{R} to be kept in their possession during travel. These individuals should be advised to take the appropriate treatment dose of Fansidar^{R} promptly in the event of a febrile illness during their travel when professional medical care is not readily available. It must be emphasized to these travelers that such presumptive self-treatment of a possible malarial infection is only a temporary measure and that prompt medical care is imperative. They should be advised to continue their weekly chloroquine prophylaxis despite presumptive treatment with Fansidar^{R}. It is essential that the treatment dosage of Fansidar^{R} and the indications for its use be explained thoroughly to travelers to areas with chloroquine-resistant P. falciparum, such as East and Central Africa, because responsibility is placed on them to recognize a potential malarial infection and, if necessary, treat themselves while abroad.

"Doxycycline alone taken daily is an alternative to the regimen described above for short term travel to areas of risk where there is chloroquine-resistant P. falciparum. It is particularly appropriate for those individuals with a history of sulfonamide intolerance.

"Regimen C: For PROLONGED travel (greater than 3 weeks) in areas where chloroquine-resistant P. falciparum IS endemic, the use of once-weekly prophylaxis with both chloroquine and Fansidar^{R} may be indicated. This regimen should be considered for: Travelers to areas where the transmission of chloroquine-resistant P. falciparum is most intense (such as East and Central Africa, Papua New Guinea, Irian Jaya, Solomon Islands, Vanuatu); travelers to areas where there is limited availability of medical care; and travelers who are elderly, immunocompromised, or who have other significant underlying medical conditions. The potential benefit of the routine prophylactic use of Fansidar^{R} for these travelers must be weighed against the risk of a possible serious or fatal adverse reaction. If weekly use of Fansidar^{R} is prescribed, the traveler should be cautioned about the possible side effects as described in the section on adverse reactions."

(Copies available upon request from the Bureau of Epidemiology, 538-6191)

Reference: [1]Adapted from Centers for Disease Control, U.S. Public Health Service, Advisory Memorandum No. 88, April 7, 1986



1986 Annual Health Fair a Big Success

The Wasatch County Health Fair, sponsored by the County Health Department, in conjunction with KUTV Channel 2 and Health Fair U.S.A., was held at the Middle School last Saturday, April 26th. Two hundred sixty people attended, 93 of whom parted with a little of their blood for chemistry analysis.

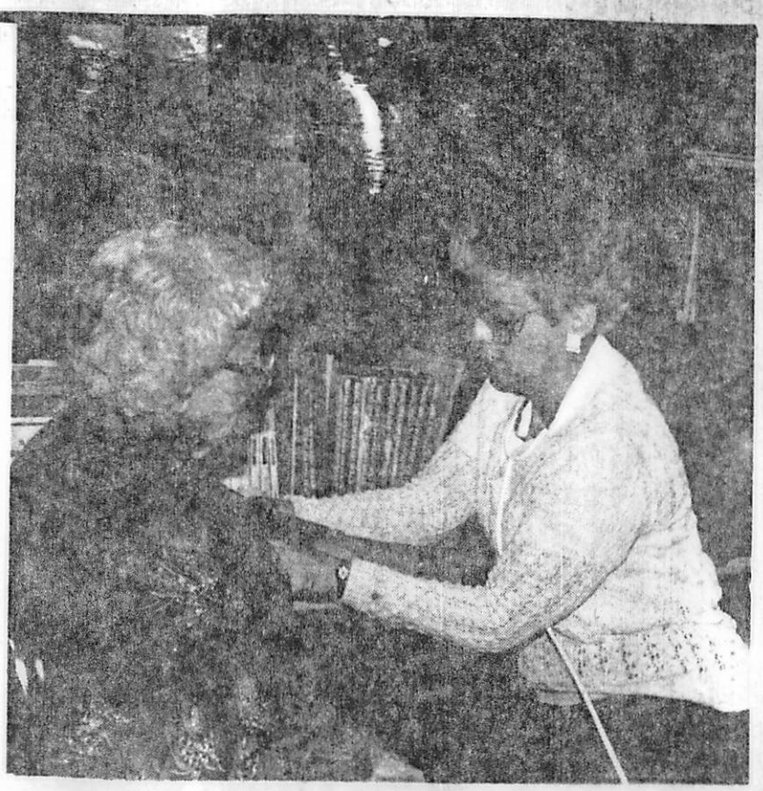
The blood test provides an inexpensive screening for diabetes, thyroid and liver problems, and provides a coronary risk profile. Results and explanations of the tests will be returned to patients in about eight weeks.

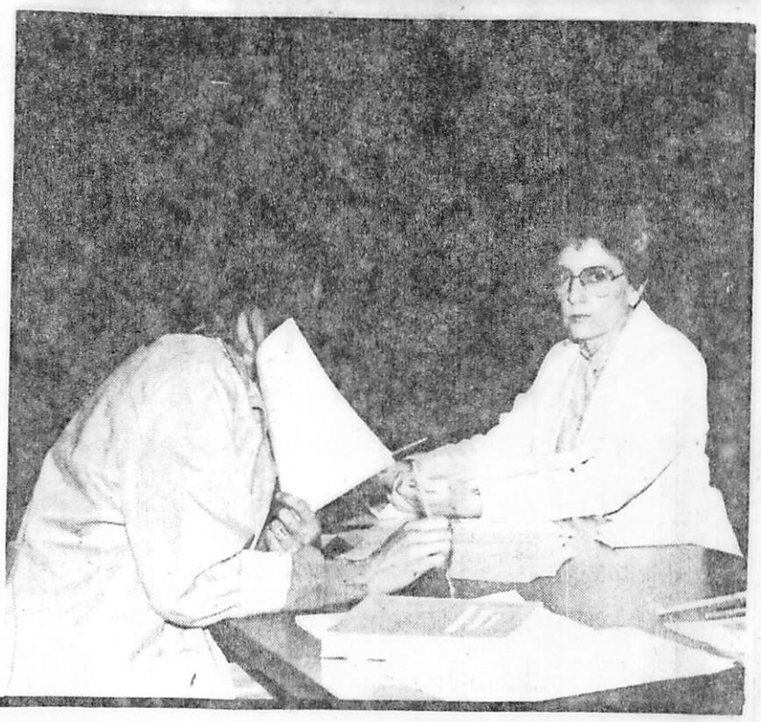
Coral Mangus, site coordinator, said that attendance this year was greater than in 1985 and she hopes it will increase again next year. She said one of the highlights both years has been the skin cancer screening booth. Another favorite this year was the fingerprinting booth for school children which was run by Troy Taylor, as a project to help him get his Boy Scout Eagle medical personnel. Eric Allred was in charge of publicity and obtaining local sponsors. He was assisted by Patrick Sullivan who also used this project to help him earn his Eagle Badge. Maxine Oakeson and the local Health Department staff kept things going smoothly and filled in where they were needed. Sue Christensen, Jody Pugh and Vicki Taylor were in charge of volunteers. Lorrie Clouser chaired the First Baptist Church which provided sandwiches that were greatly appreciated by those who had fasted for twelve hours for their blood tests. Miss Mangus also expressed special appreciation to all the phlebotamists (those who took the blood) who volunteered.

Local sponsors were Apple A Day, Day's Market, The Leavitt Group Insurance Co., and Wasatch County Hospital.

Miss Mangus said that although people today are more health conscious than ever before, they are also faced with higher-than-ever medical costs

86 Annual alth Fair Big Success





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Miss Mangus said that although people today are more health conscious than ever before, they are also faced with higher-than-ever medical costs. The purpose of the Health Fair is to bring awareness, information, and health screening to the community, at very low cost, and hopefully, people who haven't yet attended will plan to do so next year.

ppened This Way

oned. That will do the

other hand, if you are r success, just reverse e procedure. Simple,

sing is the big thing. hy ad in your local rever it is, that gives as best you can. Do something like "two old school house" be any of your customers ut-of-towners, and e no more idea where ool house is than they where the people who Louvre are buried. some stiff cardboard, h cut up boxes, and have one) start getting ready way before holding the actual event. Get your signs made. That is fun. Clean the things that should be cleaned. That is work. You'll recognize it by the fatigue. Mostly mental. Apprehension, they call it. (Among other things). But spic and span dishes, clothes, furniture, soft ware, etc., come under this heading. Chest of drawers, TV stands, and so forth could become more saleable with a coat of wax. If you have an antique bed head, better that you sell it as is, unless you spra white with a good quality aint. White ie an old standby. nc it should bring you a fe more marks, or rubbing with steel wool could reduce values drastically. Of course, if they are small items, and greasy, best that you soak them in, say, kerosene, or paint thinner maybe. You don't have to get it spotless, just degreasey.

To get back to the sales, you may have several people ask if you would take less than the listed price. Two ways to handle it. Either ask them what they would be willing to pay, or in a nice way let them know that you would have to get that much out of it to make it worth selling. Of course you leave yourself a little leeway. It is a good idea to have a couple of things m rked "make good a price, but seem to sell.

Of course, I could go on and on here, but in our opinion these are the basics.

A good newspaper ad, stating some of the principles, the time and the address. A nice clever display, with most of the small items on tables. All articles plainly marked for price. Good signs stationed within two blocks or so of the sale, with arrows pointing the way. And for heaven sakes a warm friendly greeting above all else. Remember, they are coming into your store, and it is up to you to make your prospective customers feel wanted. Otherwise they will fade fastly. Don't feel ashamed if you

In Deer Creek Reservoir

Wasatch County Working To Improve Water Quality

By JOSEPHINE ZIMMERMAN
Herald Staff Writer

Extensive work is underway in Wasatch County to improve water quality in Deer Creek Reservoir and in the proposed Jordanelle Reservoir, Robert Mathis, Wasatch County planning director, told the Central Utah Water Conservancy District's Engineering and Operation Committee Thursday.

"Deer Creek Reservoir is becoming eutrophic, meaning it has too much algae because too much phosphorus is getting into the reservoir, and this reduces the fish population," Mathis said.

"Too much phosphorus also causes taste and odor problems, but if you treat it with chlorine, it causes other problems. Since Provo River is a primary water quality resource, it deserves protection."

Mathis told the board that a comprehensive water quality plan was developed, and an extensive effort has been underway to implement it.

The water quality plan developed for the area has been a cooperative effort by more than 30 federal, state, local and private agencies. The cities, counties and various agencies have already spent more than $20 million in water quality control efforts to date and are committed to continue.

Three years of investigation went into development of the 1984 plan.

Under the plan, the goal of improving water quality in both reservoirs by reducing the input of pollutants (mainly phosphorus) can be achieved in four ways: (1) land application of municipal wastes, (2) construction of Jordanelle reservoir, (3) control of dairy and feed lot wastes, and (4) erosion control measures on the watershed.

To cut down on the phosphorus and pollution going into the streams, Wasatch County has targeted the elimination of wastewater discharges, he said. The sewage treatment system for Heber City and Midway was one of the first projects completed.

Water from this system is pumped to an alfalfa field, rather than being allowed to go into the river.

Elimination of dairy feed lot discharges has also been targeted.

Mathis showed "before and after" slides of feed lots that once had streams running through them that the animals drank from and walked in. These streams have been piped through the feed lots, and the dairies have been equipped with water troughs, holding ponds and manure bunkers that do not pollute the streams.

He said the Soil Conservation Service has assisted in the feedlot improvements.

Erosion control in the ski areas and logging areas has also been done to help eliminate runoff into the streams.

"Even though there has been some cleanup, there is still a lot to be done," he reported.

Richard Sweet, on left, Utah State Food Service Evaluation Officer, presents award to Phil Wright, Wasatch County Health Department, for attaining Utah's most-improved sanitation level in the food service program, 1982-1985.

County's Cleanliness Example to State

15 May 1986

Phil Wright, Director of the Wasatch County Health Department, received a plaque from Richard Sweet, Utah State Food Service Evaluation Officer, at the May 7 commission meeting, because of his success in raising sanitation standards in the county restaurants. The presentation was sponsored by the Utah Restaurant Association and the Utah Department of Health.

Sweet said, "Phil Wright is an example to the health departments in the rest of the state who have the same financial and personnel problems. In 1982, Wasatch County rated at the bottom in the evaluation, which is taken every three years, and was never known for its high level of sanitation. But the 1985 evaluation placed Wasatch County in a tie for third in the state." He said he had accompanied Wright on some of his inspection tours and was especially impressed at how well he was received by restaurant, motel and pool managers, indicating a rapport which is important in this cooperative effort.

Wright expressed his emphatic appreciation to the restaurant owners who have invested time and money to maintain and/or raise their sanitation standards to the level that qualified him for the award.

Utah School Immunization Act

19 June 1986

It's the law! Children must be adequately immunized before attending Utah schools and child care facilities. The Utah School Immunization Act, enacted in 1982, requires that all students in kindergarten through twelfth grade and children attending licensed child care facilities must be immunized against seven childhood diseases before attendance. Exemptions may be allowed for medical, religious or personal reasons.

All 50 states require immunizations for school entry. The adoption of school immunization laws, probably more than any other factor, has been responsible for the dramatic improvement in immunization levels and decline in childhood diseases.

Although 93.8% of Utah's

contributed to the lower immunization levels and the largest outbreak of pertussis (whooping cough) in Utah since 1964. In 1985, 60 cases of pertussis were reported in Utah, compared with only 7 cases in 1984. Fifteen (25%) of the pertussis patients required hospitalization during that outbreak. The American Academy of Pediatrics and the U.S. Public Health Services Immunization Practices Advisory Committee have reemphasized that the risk from pertissis disease is much greater than any risk from the vaccine. All medical groups continue to strongly recommend DTP vaccine for all children under seven years of age who have no valid medical reason for not receiving the vaccine.

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Although 93.8% of Utah's kindergarten students were fully immunized in 1985-86, this represents a decline from the previous school year's 94.3% level. The minimum goal nationally is 95%.

Recent adverse publicity regarding reactions associated with DPT (Diptheria, Tetanus and Pertussis) vaccine may have contributed to the lower immunization levels and the largest outbreak of pertussis (whooping cough) in Utah since 1964. In 1985, 60 cases of pertussis were reported in Utah, compared with only 7 cases in 1984. Fifteen (25%) of the pertussis patients required hospitalization during that outbreak. The American Academy of Pediatrics and the U.S. Public Health Services Immunization Practices Advisory Committee have reemphasized that the risk from pertissis disease is much greater than any risk from the vaccine. All medical groups continue to strongly recommend DTP vaccine for all children under seven years of age who have no valid medical reason for not receiving the vaccine.

Utah Department of Health officials strongly urge parents to comply with the law and protect their children from the debilitating effects of vaccine preventable diseases.

Additional information on immunizations is available from the Utah Department of Health, 538-6191, or your local health department.

19 May 1986 Bd Health.

May flower — Craig Schmay
Clark Mower

Bureau of Reclamation:

State Bd of Health: — Hazardous Waste
water Quality
& Pollution Control

Local Wasatch Co Bd. Health:

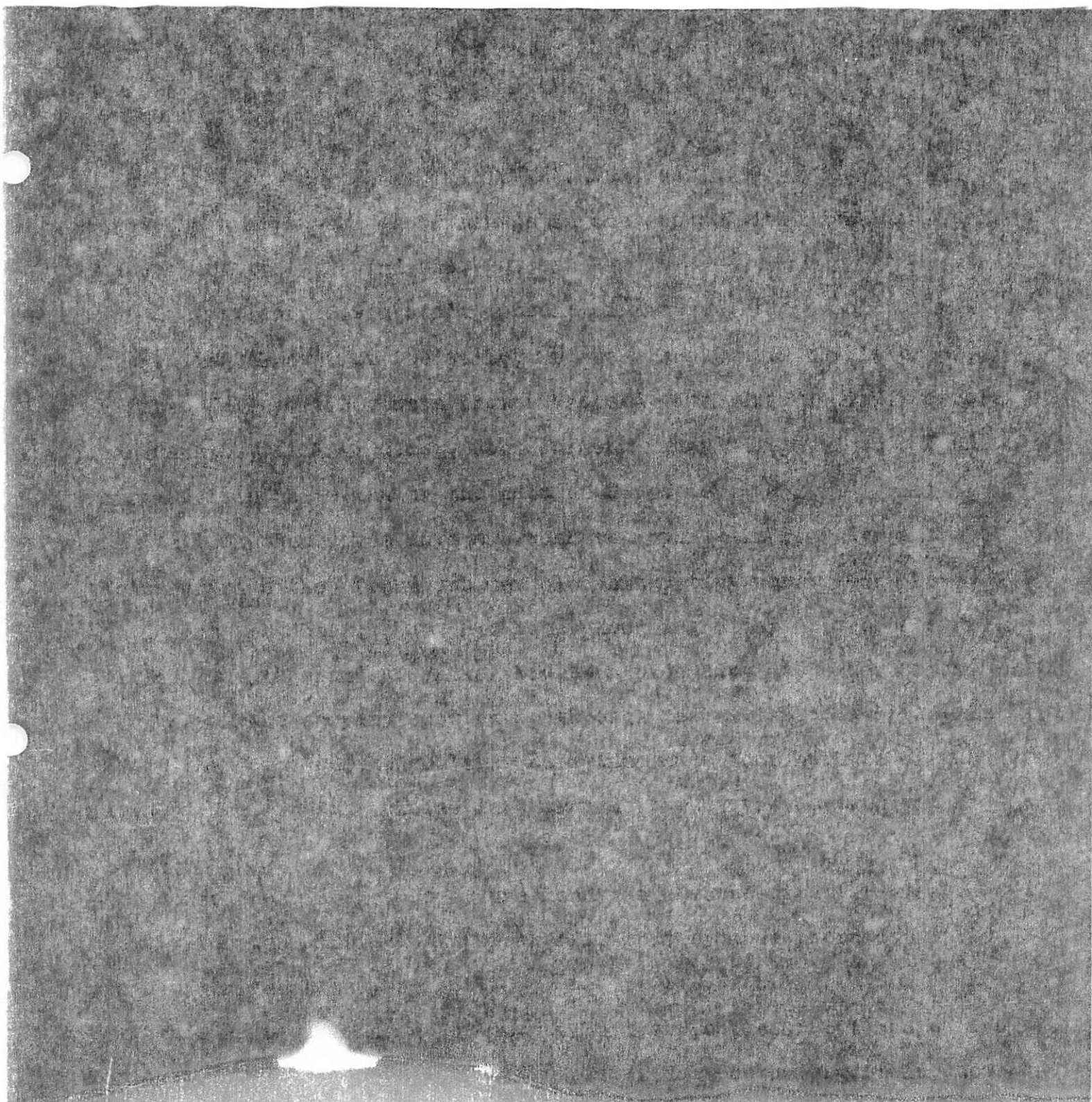
Our Position:
1. We need to know how much of what we have at 2 locations — Mayflower Peterhead sites.
2. How it will be handled
3. Then ask State Bd. Health — will that method contain our Problem.
4 Maintain water Quality.

EPA — Priority

May 1956 Bd Health

May flower Iris Library

Clark Mowers



MINUTES OF THE WASATCH CITY-COUNTY BOARD OF HEALTH

May 19, 1986 12:00 P.M. County Services Complex

Present were:	Calvin Giles	Chairman
	Connie Tatton	Vice-chairman
	Rulon Phillips	Member
	R.C. Tadd	Commissioner
	Phil Wright	Health Officer
	Maxine Oakeson	Nurse Supervisor
	Maren Durtschi	Nurse
	Ranae Williams	Nutritionist-Educator
	Larry Carcelli	Mental Health
	Jeff Bradshaw	School Board Rep.
	Robert Blanthorn	Alcohol-Drug Director
	Joe Tesch	County Attorney
	Nelda Duke	Secretary
Excused:	Elizabeth Murdock	
	R. Raymond Green	

Welcome: Mr. Giles welcomed those present and called the meeting to order.

Invocation: The invocation was offerd by Mrs. Tatton.

Minutes: Minutes of the meeting held April 21, 1986 were read by Mrs. Duke. Commissioner Tadd made a motion minutes be approved as read. Mrs. Tatton seconded the motion. Motion carried.

Mental Health: Mr. Carcelli reported his parenting group is going very well. This group meets each Monday evening at at 6 PM in the social services building. His program seems to be going very smoothly.

School Health: Mrs. Durtschi reported she had finished eye testing in the schools and has been working on scoliosis screening. She had 36 students re-checked by Dr. Green and 6 were referred for further care. She stated she had also picked up some foot and overweight problems.

Immunization: Mrs. Oakeson said that results from our immunization audit shows our immunization level is 97.7%. She complimented Mrs. Durtschi for her excellent work in getting the school children immunized. (See copy #1).

WIC: Mrs. Williams reported we now have 349 clients on our WIC program. Our funds will remain the same as we are not affected by Gramm Rudman Act.

Pregnancy Testing: Mrs. Oakeson said she had checked with other health departments regarding pregnancy testing and found Uintah does testing, Utah does not test but it is available at their hospital. Summit County does not test but it is available at the Park City Clinic. Mr. Tesch, Attorney, said if testing is done under specific regulations he could not see a problem with liability.

Immunization Cost: Mr. Wright stated at the last health officers meeting they discussed the rising cost of immunizations. The state will allow us to charge up to $2 per dose to administer vaccine. After some discussion Mrs. Tatton made a motion we change our cost of administering vaccine from $2 per child to $2 per dose. Mr. Phillips seconded the motion. Motion carried.

Well Child: Mrs. Oakeson said the well child clinics are going quite will. We have referred several children for further treatment.

Joint Meeting:

The board then held a special session with representatives interested in the Olsen-Neihart tailings problem. Those present were:

John Trepanonshi	Dept of Health
Stephen Noyes	Bureau of Reclamation
Mike Sullivan	Chamber of Commerce
Lorin Allred	Wasatch Co. Commissioner
Lee Roy Farrell	Wasatch Co. Bldg. Insp.
Jay Henrie	Bureau of Reclamation
Chuck Lane	Bureau of Reclamation
Craig Smay	Mayflower Attorney
Clark Mower	Mayflower
Pete Coleman	Wasatch Co.Commissioner
Robert Mathis	Wasatch Co. Planner

Board members as listed above

Mr. Wright stated the purpose of the meeting was to inform board members as to what plans were being made to take care of the Olson-Neihart tailings.

Craig Smay, attorney for Mayflower, stated the tailings contain heavy metals that might contaminate water supplies and they are planning on a study for potential hazards and the state will assist in the study.

Mr. Henri of the Bureau of Reclamation said they were putting out an environmental impact statement.

Mr. Mathis, Wasatch County Planner stated the county and state had developed a plan stating no building permits can be issued until a clearance is given. He felt it would take too long to get this problem resolved and perhaps their needs to be a change in the plan. Possibly negotiations between the bureau and developers would help with this problem.

Mr. Wright said he would rely heavily on the state in this project.

It was stated that the money was now available to purchase the right of way for the Jordanelle dam. The construction of the highway will begin in the Spring of 1987 and dam construction in the Spring of 1988.

It seemed to be the feeling of each representative that they would be willing to cooperate in this development program.

As there was no other business the joint meeting was adjourned and special guests excused.

By-laws: Mr. Wright stated our board had never adopted by-laws. He submitted a copy and asked Attorney Tesch to explain them and answer any questions the board members may have. After some discussion the members were asked to take a copy of the by-laws and study them so we can make a decision at our next meeting.

Alcohol/ Drug Report: Mr. Blanthorn reported he now had 17 clients (19 is capacity). He has released 4 or 5 clients recently with positive results. He has had some problems with a contract with TCMHC and a meeting is set up for next week to help resolve the problem.

Hib Vaccine: Mrs. Oakeson stated we have ordered 60 doses of Hib vaccine. There was some discussion as to what we would charge per dose. Mrs. Tatton made a motion we charge $7.00 per dose for administering the Hib vaccine. Commissioner Tadd seconded the motion. Motion carried.

Health Fair: Mrs. Oakeson reported approximately 200 people attended the Health Fair and we felt it was very successful. Mr. Wright said he would contact the hospital and see how they felt about sponsoring it next year.

Contracts:	Mr. Wright stated contracts from the state are due again. This year the state is not requiring commissioners signatures on the contracts. He asked Commissioner Tadd how he felt about this. Commissioner Tadd said as long as Mr. Wright signs the contracts it is okay with him. Mr. Wright said we would keep the commissioners abreast of all contracts we receive.
Ex-officio Member:	Mr. Wright asked how the board felt about getting an ex-officio board member to represent food service in the county. There was not time for further discussio on this matter.
Wallsburg Sewage Problem:	Mr. Phillips asked about the sewage problem in Wallsburg. Mr. Wright said he had looked into the problem and is now monitoring it.
Asbestos Survey:	Mr. Wright said some samples sent in from the asbestos survey showed they contained asbestos.
Deer Creek:	Mr. Wright said Doug Wagstaff had been awarded the Charleston Bridge and Island Boat Camp concessions on a 20 year lease. He is planning on building a restaurant at Island Boat Camp. He will probably have to pump sewage and water may be a problem.
Next Meeting:	The next meeting is scheduled for Monday, June 16th at 12:00 noon in the County Services Complex Building.

Meeting was adjourned at 2:50 P.M.

_____
Chairman

Copy #1

STATE OF UTAH
DEPARTMENT OF HEALTH

NORMAN H BANG . GOVERNOR

SUZANNE DANDOY, M.D., M.P.H., EXECUTIVE DIRECTOR

April 29, 1986

Mark Rasband, Principal
Central School
301 South Main
Heber City, Utah

Dear Mr. Rasband:

The Immunization Program, Utah Department of Health has completed an audit of the immunization records of all kindergarten students in your school. Your school was selected from a random sample of schools statewide. The 1985-86 random sample included elementary schools (kindergarten), middle or junior high schools (7th grade), high schools (10th grade) and licensed child-care facilities. Although the law will continue to apply to all (licensed child-care facilities and K-12) students, the assessment reports due to be submitted by November 30, 1986 (1986/87 school year) will be required only for kindergarten students, all transfer students (K-12), and the licensed child-care facilities (including pre-schools and Headstart).

The audit of immunization records at your school indicated the following results:

1. 99.3 of the students were unconditionally enrolled (all requirements met). This compares to 99.6 reported unconditionally enrolled by your school on the Immunization Assessment of School Students - Annual Report.

2. .7 of the students were conditionally enrolled (all requirements not met). This compares to .4 reported conditionally enrolled by your school on the annual report.

3. 1.5 of the students had on file a Religious, Medical or Personal Exemption. This compares to 1.4 reported exempt on the annual report.

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

J. Brett Lazar, M.D., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 538-6191

MONTH June YEAR 1986

CONTENTS

MEASLES ALERT

The first measles cases in Utah since 1984 have occurred among children from Davis County. None of the cases had been immunized. The index case, a 4-year-old male, had onset of symptoms including typical measles rash during mid-April, approximately two weeks after returning to Utah from California. The child was suspected as having Coxsackie virus disease and was treated with amoxycillin. No blood specimens were collected for testing. Prior to onset of illness , the patient attended a neighborhood nursery group with approximately 16 other children, and subsequently spread the disease to a 5-year-old boy, who developed a rash during early May. This child (Case 2) had a history of bronchitis and was seen by his physician who diagnosed the condition as bronchitis with rash. On days when Case 2 did not attend the nursery group, he was enrolled in a neighborhood preschool.

A 4-year-old female (Case 3) who attended the preschool came down with symptoms and rash during mid-May. She was seen by her physician who diagnosed measles and requested blood specimens which showed acute and convalescent titers of $<$1:8 and 1:64 respectively.

Preschool contact with Case 3 resulted in Cases 4 and 5, sisters, ages 5 and 3, who presented with clinical signs and symptoms, including rash during the first week of June. The sisters were seen by their physician who diagnosed measles and drew acute and convalescent blood specimens which showed a rising titer from $<$1:8 to 1:128 for both girls.

The two sisters (Cases 4 and 5) had contact with a 7-year-old female (Case 6) who did not attend the preschool. Case 6 developed clinical measles and was serologically confirmed as a case.

Importation of measles from California has resulted in four serologically confirmed cases and two epidemiologically-linked cases. All of the cases were preventable and concentrated mainly among unimmunized preschool children over 15 months of age.

The Utah Department of Health is increasing surveillance for rubeola cases and is urging physicians to promptly report suspect cases and submit specimens for serologic confirmation.

INFLUENZA VACCINE
RECOMMENDATIONS FOR 1986-1987

The Immunization Practices Advisory Committee (ACIP) has issued recommendations for prevention and control of influenza during the 1986-1987 season.[1] The recommendations, in addition to reviewing strategies to protect the public against infection, also contain several changes to past statements.

Changes include addition of statements about: (1) updating of the influenza strains in the vaccine for 1986-1987; (2) immunization and amantadine prophylaxis for household members who provide home care for high-risk persons; (3) optimal time for conducting routine vaccination programs; (4) concurrent administration of influenza vaccine and childhood vaccines; (5) immunization of children receiving long-term aspirin therapy; and (6) other sources of information about influenza and control measures.

The changes abstracted from the recommendations are reprinted below:

"RECOMMENDATIONS FOR USE OF INACTIVATED VACCINE

Influenza vaccine is recommended for high-risk persons 6 months of age or older, for their medical-care personnel and primary providers of care in the home setting, for children receiving long-term aspirin therapy, and for other persons wishing to reduce their chances of acquiring influenza illness. Vaccine composition for 1986-1987 and doses are given in Table 1. Guidelines for the use of vaccine are given below for different segments of the population. **Remaining 1985-1986 vaccine should not be used.** Although the current influenza vaccine often contains one or more antigens used in previous years, immunity declines during the year following vaccination. **Therefore, a history of vaccination in any previous year with a vaccine containing one or more antigens included in the current vaccine does not preclude the need for revaccination for the 1986-1987 influenza season to provide optimal protection.**

During the past decade, data on influenza vaccine immunogenicity and side effects were generally obtained when vaccine was administered by the intramuscular route. Because of a lack of adequate evaluation of recent

TABLE 1. Influenza vaccine* dosage, by patient age — United States, 1986-1987 season

Age group	Product†	Dosage§	No. doses	Route¶
6-35 mos.	Split virus only	0.25 ml	2**	IM
3-12 yrs.	Split virus only	0.5 ml	2**	IM
> 12 years	Whole or split virus	0.5 ml	1	IM

*Contains 15 μg each of A/Chile/1/83(H1N1), A/Mississippi/1/85(H3N2), and B/Ann Arbor/1/86 hemagglutinin antigens in each 0.5 ml. Manufacturers include Parke-Davis (Fluogen® split), Squibb-Connaught (Fluzone® whole or split), Wyeth Laboratories (Influenza Virus Vaccine, Trivalent® split). Manufacturer's phone numbers to obtain further product information are: Parke-Davis — (800) 223-0432; Squibb-Connaught — (800) 822-2463; Wyeth — (800) 321-2304.

†Because of the lower potential for causing febrile reactions, only split (subvirion) vaccine should be used in children. Immunogenicity and reactogenicity of split and whole virus vaccines are similar in adults when used according to the recommended dosage.

§Due to the accessibility of children at times when pediatric vaccines are administered, it may be desirable to simultaneously administer, particularly to high-risk children, influenza vaccine at the same time as routine pediatric vaccines or pneumonococcal polysaccharide vaccine, but in different sites. Although studies have not been done, no diminution of immunogenicity or enhancement of adverse reactions should be expected.

¶The recommended site of vaccination is the deltoid muscle for adults and older children. The preferred site for infants and young children is the anterolateral aspect of the thigh.

**Two doses are recommended for maximum protection, with at least 4 weeks between doses. However, if the individual received at least one dose of influenza vaccine recommended from 1978-1979 to 1985-1986, one dose is sufficient.

influenza vaccines administered by other routes to high-risk persons, the preferred route of vaccination is intramuscular. The recommended site of vaccination is the deltoid muscle for adults and older children and the anterolateral aspect of the thigh for infants and young children.

High-Priority Target Groups for Special Vaccination Programs

1. **Groups at greatest medical risk of influenza-related complications.** Based on observations of morbidity and mortality, high-risk groups have been classified on the basis of priority, so available resources can be particularly directed toward organizing special programs to provide vaccine to those who may derive the greatest benefit. Active, targeted vaccination efforts are most necessary for the following two high-risk groups, with the objective of vaccinating at least 80% of each group.

   a. Adults and children with chronic disorders of the cardiovascular or pulmonary systems that are severe enough to have required regular medical follow-up or hospitalization during the preceding year.
   b. Residents of nursing homes and other chronic-care facilities (i.e., institutions housing patients of any age with chronic medical conditions).

2. **Groups at moderate medical risk of influenza-related complications.** After considering the needs of the above two target groups (1a and 1b), programs are desirable that make vaccine readily available to persons at moderately increased risk of serious illness compared with the general population. These include:

   a. Otherwise healthy individuals 65 years of age or older.
   b. Adults and children with chronic metabolic diseases (including diabetes mellitus), renal dysfunction, anemia, immunosuppression, or asthma that are severe enough to require regular medical follow-up or hospitalization during the preceding year.
   c. Children receiving long-term aspirin therapy, who may be at risk of developing Reye syndrome following influenza infection.

3. **Groups potentially capable of nosocomial transmission of influenza to high-risk persons.** During many winters, nosocomial outbreaks of influenza are reported. Although not proven, it is reasonable to believe that medical personnel who provide care to high-risk persons in health-care facilities, or family members, volunteer workers, or others who are the primary providers of care to a high-risk person in the home setting, can transmit influenza infections to high-risk patients while they are themselves incubating infection, undergoing subclinical infection, or working despite the existence of mild symptoms. The potential for introduing influenza to high-risk persons should be reduced by vaccinating:

   a. Physicians, nurses, and other personnel who have extensive contact with high-risk patients (e.g., primary-care and certain specialty clinicians, staff of intensive-care units, particularly neonatal intensive-care units).
   b. Providers of care to high-risk persons in the home setting (e.g., family members, visiting nurses, volunteer workers).

Vaccination of Other Groups

1. **General population.** Physicians should administer vaccine to any person who wishes to reduce his/her chances of acquiring influenza infection. Persons who provide essential community services, such as employees of fire and police departments, are not considered at increased occupational risk of serious influenza illness but may be considered for vaccination programs designed to minimize the possible disruption of essential activities that can occur during severe epidemics.

2. **Pregnant women.** Pregnancy has not been demonstrated to be a risk factor for severe influenza infection, except in the largest pandemics of 1918-1919 and 1957-1958. However, a pregnant woman with a medical condition that increases her risk of complications from influenza should be vaccinated, as influenza vaccine is considered safe for pregnant women in the absence of a specific severe egg allergy. Nonetheless, when vaccine is given during pregnancy, waiting until after the first trimester is a reasonable precaution to minimize any concern over the theoretical possibility of teratogenicity. However, it may be undesirable to delay vaccination of a pregnant woman with a high-risk condition who will still be in the first trimester of pregnancy when influenza activity usually begins."

"Simultaneous Administration of Other or Childhood Vaccines

There is considerable overlap in the target groups for influenza and pneumococcal vaccination. Pneumococcal and influenza vaccines can be given at the same time at different sites without increased side effects, but it should be emphasized that, whereas influenza vaccine is given annually, pneumococcal vaccine should be given only once. Detailed immunization records, which should be provided to each patient, will help ensure that additional doses of pneumococcal vaccine are not given.

Because children are accessible at times when pediatric vaccines are administered, it may be desirable to simultaneously administer influenza vaccine, if indicated, with routine pediatric vaccine but at different sites. Although studies have not been done, no diminution of immunogenicity or enhancement of adverse reactions should be expected."

Because vaccination of high-risk persons each year before the influenza season is the single most important influenza-control measure, the Utah Department of Health recommends that immunization programs be initiated during the fall of each year. Influenza outbreaks in Utah usually occur after mid-December, therefore, vaccination should begin in September or October and be completed before the end of November.

Copies of the recommendations are available upon request. Practitioners may be especially interested in the expanded guidelines for the use of amantadine hydrochloride for prophylaxis and therapy of influenza virus infections which we are not able to include in this issue.

Reference:

[1] Adapted from Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 35/No. 20, May 23, 1986.

#1

LOCAL HEALTH DEPARTMENT/AGENCY
PUBLIC HEALTH SERVICE
PERFORMANCE PLAN

PUBLIC HEALTH SERVICE: BUDGET
CHILD HEALTH PROGRAM
Wasatch City-County Health Department

Fiscal Year 1986

1.	DENTAL		$ 2,681
	Extensive Care	8 children x $200 = $1,600	
	Emergency Care	13 children x $ 20 = $ 520	
		x 2 office visits	
	Dental Cleaning and Fluoride	21 children x $ 16 = $ 336	
	Fluoride chewables	100 children x $2.25= $ 225	
2.	VISION		1,200
	8 children x $150 (To pay for exam and glasses)		
3.	REFERRAL & TREATMENT URI'S FOUND IN WCC (Low Income)		1,135
	Initial office visit	17 children x $24 = $408	
	Brief visit follow-up	17 children x $11 = $187	
	Throat cultures	5 children x $ 8 = $ 40	
	Prescription	25 children x $20 = $500	
4.	ADMINISTRATION		1,000
5.	PHYSICIAN TIME		4,800
6.	NURSING SERVICES		2,000
7.	CLERICAL		600
8.	OFFICE SUPPLIES		1,000
	TOTAL BUDGET		$14,416

LOCAL HEALTH DEPARTMENT/AGENCY
PUBLIC HEALTH SERVICE
PERFORMANCE PLAN

PUBLIC HEALTH SERVICE: BUDGET
MATERNAL HEALTH FY 1986-87
WASATCH CITY-COUNTY HEALTH DEPT.

EARLY PREGNANCY CLASSES:

PHN Salary	30 hrs	418	
Nutritionist Salary	10 hrs	168	
Travel allowance		140	
Hospitality		50	
Information Packets		100	
		TOTAL	$ 876.00

PREGNANCY TESTING:

PHN Salary	10 hrs	166	
Test Kits		60	
		TOTAL	226.00

BREAST FEEDING SUPPORT PROGRAM:

PHN Salary	60 hrs	1000	
Misc. Supplies: shields, pumps, ed. charts, etc.		100	
		TOTAL	1100.00

PRENATAL CARE:

M.D. Fees	5 clients @ $600	3000	
Basic Lab.		800	
Charts/records		50	
Limited Meds.		400	
Limited A/P diag.		400	
Ped. PE	@ 40	200	
PHN Salary	10 hrs	167	
		TOTAL	5017.00

OFFICE SUPPLIES		200	
ADMINISTRATION		400	
		TOTAL	600.00

Summary of Total Costs			
Salaries & Benefits	$1919		
M.D.Services	3000	GRAND TOTAL	$ 7819.00
Lab fees, tests,etc	1850		
Special Supplies	310		
Travel	140		
Office Supplies	200		
Administration	400		
Total Maternal H Budget	$ 7819		

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

J. Brett Lazar, M.D., M.P.H., Director
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EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 538-6191

MONTH July YEAR 1986

CONTENTS

INFANT BOTULISM

Infant botulism was first recognized as a distinct clinical entity in 1976, with the first cases in Utah being reported during 1977. During the past ten years, 32 cases of infant botulism have occurred in Utah. Nineteen of the cases were males (59%). Ages ranged from 5 weeks to 1 year; the majority (91%) were less than 6-months-old. More than half of the total cases (17/32 = 53%) had onset during the three-year period, 1977-1979, before honey was recognized as a source of Clostridium botulinum spores. Parents should be sure that honey is not fed to any child 12 months of age or less.

The most recent case of infant botulism was reported during July. This is the first confirmed case since September 1984. The patient, an 8-month-old male, received only breast milk until he developed symptoms (constipation, ptosis, weakness and poor feeding) and received supplemental feedings of formula. The baby ate no other foods except for a limited amount of fruit juices. The child was exposed to extremely dusty environments, including a cattle drive, prior to illness.

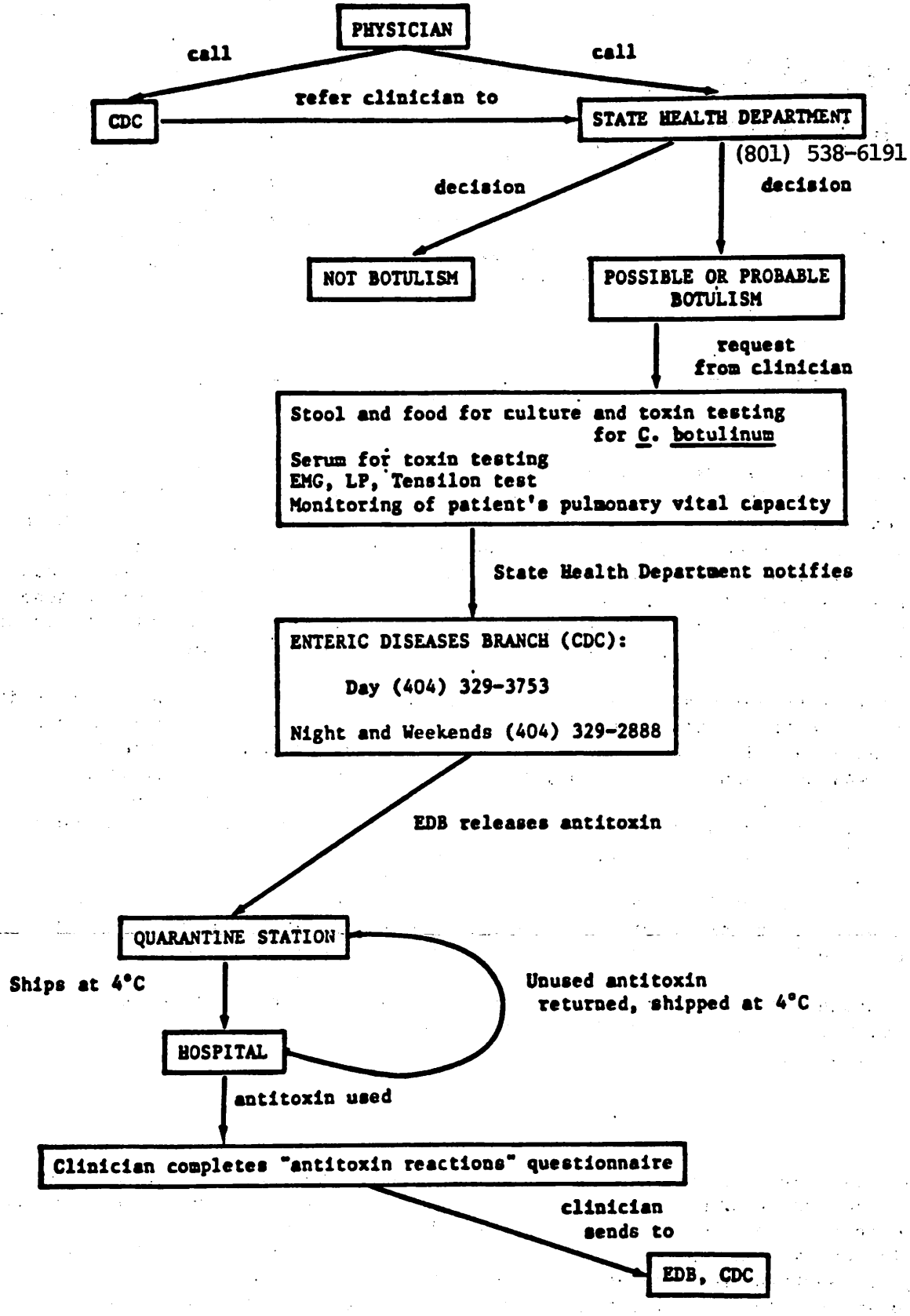
Stool specimens from the patient contained C. botulinum type A toxin. Infant botulism cases in Utah and west of the Mississippi are usually caused by type A toxin, as C. botulinum type A spores are common in soils.

Although the role of dust in the development of disease is not well defined, the Bureau of Epidemiology recommends that infants not be exposed to excessive dust.

BOTULISM ANTITOXIN

Botulism antitoxin is no longer maintained by the Bureau of Epidemiology due to limited national supply and high cost ($263/vial). Physicians needing antitoxin for treatment of a suspect botulism case should be aware that supplies are maintained by quarantine stations and can be sent to Utah by air freight. Approval must be obtained from the Utah Department of Health before antitoxin is released. The algorithm on the following page clarifies the proper sequence of events to be followed when a suspect case occurs. Recently, antitoxin arrived within six hours of our request.

ALGORITHM FOR SUSPECTED CASE OF BOTULISM



Diagnosis and Management of Mycobacterial Infection and Disease in Persons with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus Infection[1]

In 1985, the number of new tuberculosis cases reported to CDC was essentially the same as that reported in 1984 (*1*). In contrast, the average annual decline in morbidity during the past 32 years has been 5%. The failure of tuberculosis morbidity to decline as expected in 1985 is probably related to the occurrence of tuberculosis among persons with acquired immunodeficiency syndrome (AIDS) or human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV/LAV)* infection. Several reports have indicated that mycobacterial disease is common among AIDS patients and among persons at risk for AIDS (*2-9*). The most common mycobacterial species isolated from patients with diagnosed AIDS is *Mycobacterium avium* complex (MAC), although in some groups in which tuberculous infection is highly prevalent, disease caused by *M. tuberculosis* is more common (*10-12*). Even among groups in which MAC is the most common mycobacterial pathogen, *M. tuberculosis* accounts for a substantial proportion of the mycobacterial isolates. The association between mycobacterial disease and AIDS raises several important clinical and public health issues that are addressed below.

DIAGNOSIS OF TUBERCULOSIS IN PATIENTS LIKELY TO HAVE HTLV-III/LAV INFECTION

Clinicians should consider the diagnosis of tuberculosis in patients with, or at risk of, HTLV-III/LAV infection, even if the clinical presentation is unusual (*4,13,14*). Available data indicate that extrapulmonary forms of tuberculosis, particularly lymphatic and disseminated (miliary), are seen much more frequently among patients with HTLV-III/LAV infection than among those without such infection. Pulmonary tuberculosis in patients with HTLV-III/LAV infection cannot readily be distinguished from other pulmonary infections, such as *Pneumocystis carinii* pneumonia, on the basis of clinical and radiographic findings. Patients with tuberculosis may have infiltrates in any lung zone, often associated with mediastinal and/or hilar lymphadenopathy. Cavitation is uncommon. Appropriate specimens to establish a culture-confirmed diagnosis of tuberculosis include respiratory secretions, urine, blood, lymph node, bone marrow, liver, or other tissue or body fluid that is indicated clinically. All tissue specimens should be stained for acid-fast bacilli and cultured for mycobacteria. In the presence of undiagnosed pulmonary infiltrates, bronchoscopy with lavage and transbronchial biopsy (if not contraindicated) may be needed to obtain material for both culture and histologic examination. A tuberculin skin test should be administered, but the absence of a reaction does not rule out the diagnosis of tuberculosis because immunosuppression associated with HTLV-III/LAV infection may cause false-negative results.

*The Human Retrovirus Subcommittee of the International Committee on the Taxonomy of Viruses has proposed the name human immunodeficiency virus (HIV) for this virus (Science 1986;232:697).

TREATMENT OF MYCOBACTERIAL DISEASE IN A PATIENT WITH HTLV-III/LAV INFECTION

Chemotherapy should be started whenever acid-fast bacilli are found in a specir from a patient with HTLV-III/LAV infection and clinical evidence of mycobacterial ease. Because it is difficult to distinguish tuberculosis from MAC disease by any criterion other than culture, and because of the individual and public health implications of tuberculosis, it is important to treat patients with a regimen effective against tuberculosis. With some exceptions, patients with tuberculosis and HTLV-III/LAV infection respond relatively well to standard antituberculosis drugs (*15*); however, their treatment should include at least three drugs initially, and treatment may need to be longer than the standard duration of 9 months (*16*). The recommended regimen is isoniazid (INH), 10-15 mg/kg/day up to 300 mg/day; rifampin (RIF), 10-15 mg/kg/day up to 600 mg/day; and either ethambutol (EMB), 25 mg/kg/day, or pyrazinamide (PZA), 20-30 mg/kg/day. The last two drugs are usually given only during the first 2 months of therapy. The addition of a fourth drug may be indicated in certain situations, such as central nervous system or disseminated disease or when INH resistance is suspected. An initial drug-susceptibility test should always be performed, and the treatment regimen, revised if resistance is found to any of the drugs being used. The appropriate duration of treatment for patients with tuberculosis and HTLV-III/LAV infection is unknown; however, it is recommended that treatment continue for a minimum of 9 months and for at least 6 months after documented culture conversion. If INH or RIF is not included in the treatment regimen, therapy should continue for a minimum of 18 months and for at least 12 months following culture conversion. After therapy is completed, patients should be followed closely, and mycobacteriologic examinations should be repeated if clinically indicated.

Some clinicians would take a different approach to treatment than that outlined above, to cover the possibility of MAC disease. Although the clinical significance and optimal therapy of MAC disease in these patients is not well defined, and there are no definitive data on the efficacy of treatment, one regimen commonly used to treat MAC disease substitutes rifabutin (ansamycin LM 427) for rifampin, combined with INH, EMB, and clofazimine. Rifabutin and clofazimine are experimental drugs available to qualified investigators only under investigational new drug protocols. Rifabutin is distributed by the CDC Drug Service (telephone: [404] 329-3670), and clofazimine, by Ciba-Geigy: (telephone: [201] 277-5787). If *M. tuberculosis* is isolated from a patient receiving this four-drug regimen, treatment should be switched to one of the three-drug regimens outlined above (INH, RIF, and EMB or PZA). If MAC is isolated from a patient who has been started on a three-drug regimen, the clinician may continue the three-drug regimen or switch to the four-drug regimen of INH, EMB, rifabutin, and clofazimine.

Although experience is very limited, patients with disease due to *M. kansasii* should respond to INH, RIF, and EMB. Some clinicians advocate the addition of streptomycin (SM), 1 gram twice weekly, for the first 3 months. Therapy should continue for a minimum of 15 months following culture conversion.

Monitoring for toxicity of antimycobacterial drugs may be difficult for patients who may be receiving a variety of other drugs and may have other concomitant conditions. Because hepatic and hematologic abnormalities may be caused by the mycobacterial disease, AIDS, or other drugs and conditions, the presence of such abnormalities is not an absolute contraindication to the use of the treatment regimens outlined above.

INFECTION CONTROL

Recommendations for preventing transmission of HTLV-III/LAV infection to health-care workers have been published (*17*). In addition, infection-control procedures applied to patients (HTLV-III/LAV infection who have undiagnosed pulmonary disease should always take the oility of tuberculosis into account. This is especially true when diagnostic procedures, such as sputum induction or bronchoscopy, are being performed. Previously published guidelines for preventing tuberculosis transmission in hospitals should be followed (*18*).

CONTACT INVESTIGATION FOR TUBERCULOSIS

Patients with pulmonary tuberculosis and HTLV-III/LAV infection should be considered potentially infectious for tuberculosis, and standard procedures for tuberculosis contact investigation should be followed (*19*). Specific data on the infectiousness of tuberculosis in patients with HTLV-III/LAV infection are not yet available.

EXAMINING HTLV-III/LAV-INFECTED PERSONS FOR TUBERCULOSIS AND TUBERCULOUS INFECTION

Individuals who are known to be HTLV-III/LAV seropositive should be given a Mantoux skin test with 5 tuberculin units of purified protein derivative as part of their clinical evaluation. Although some false-negative skin test results may be encountered in this setting as a result of immunosuppression induced by HTLV-III/LAV infection, significant reactions are still meaningful (*20*). If the skin test reaction is significant, a chest radiograph should be obtained, and if abnormalities are detected, additional diagnostic procedures for tuberculosis should be undertaken. Patients with clinical AIDS or other Class IV HTLV-III/LAV infections (*21*) should receive *both* a tuberculin skin test and a chest radiograph because of the higher probability of false-negative tuberculin reactions in immunosuppressed patients.

EXAMINING PATIENTS WITH CLINICALLY ACTIVE TUBERCULOSIS OR LATENT TUBERCULOUS INFECTION FOR HTLV-III/LAV INFECTION

As part of the evaluation of patients with tuberculosis and tuberculous infection, risk factors for HTLV-III/LAV should be identified. Voluntary testing of all persons with these risk factors is recommended (*22*). In addition, testing for HTLV-III/LAV antibody should be considered for patients of all ages who have severe or unusual manifestations of tuberculosis. The presence of HTLV-III/LAV infection has implications regarding treatment (see above), alerts the physician to the possibility of other opportunistic infections, and allows for counselling about transmission of HTLV-III/LAV infection (*23*). Testing for HTLV-III/LAV antibody is especially important for persons over age 35 with *asymptomatic* tuberculous infection, because INH would not usually be indicated for persons in this age group unless they are also HTLV-III/LAV seropositive.

PREVENTIVE THERAPY

HTLV-III/LAV seropositivity in a person of any age with a significant tuberculin reaction is an indication for INH preventive therapy (*16*). Although it is not known whether INH therapy is as efficacious in preventing tuberculosis in HTLV-III/LAV-infected persons as in other groups, the usually good response of HTLV-III/LAV-infected persons with tuberculosis to standard therapy suggests that INH preventive therapy would also be effective. Before instituting preventive therapy, clinically active tuberculosis should be excluded.

Developed by Center for Prevention Svcs, Center for Infectious Diseases, CDC, with consultation from: RS Holzman, MD, New York University Medical Center, New York City; PC Hopewell, MD, San Francisco G[illegible]ral Hospital Medical Center, California; AE Pitchenik, MD, University of Miami Medical Center, Flori(Reichman, MD, University of Medicine and Dentistry of New Jersey, New Jersey Medical School, sity Hospital, Newark, New Jersey; RL Stoneburner, MD, New York City Dept of Health.

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1 Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 35/No. 28, July 18, 1986.

WASATCH CITY-COUNTY HEALTH DEPARTMENT

P.O. BOX 246
805 WEST 100 SOUTH
HEBER CITY, UTAH 84032
PHONE (801) 654-2700

July 9, 1986

Dear Dr. Green,

Due to circumstances beyond our control we have found it necessary to schedule our next board meeting for Tuesday, July 22nd 12:00 noon in the health offices.

I hope this time will be convenient for you and you will be able to attend.

Sincerely,

Nelda

Mahoney request to sale of lots & allow bldg. before water is in

AGENDA

Board of Health

July 22, 1986 12:00 PM Wasatch County Services Complex

Alcohol/Drug Report:

Nursing Report:

- School Health
- WIC - 339
- Immunization -
- Hypertension
- Well Child -
- Nurse Director Recruitment

Environmental Health:

- Forest Service Complex
- Mayflower Tailings
- Daniel Summit Estates
- Strawberry Lake Estates
- County Mobil Home Status
- Current Creek Sewage Problem -
- Keetley Water -
- Strawberry Water Users Development
- Dead Animal Problem

Liability Insurance:

By-Laws:

Other Business: